North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

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Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Richard J. Visingardi, Ph.D, Director

September 8, 2003

MEMORANDUM

To: Legislative Oversight Committee Members
MH/DD/SAS Commission
Consumer/Family Advisory Committee Chairs
Advocacy Organizations and Groups
North Carolina Association of County Commissioners
County Managers
County Manager Chairs
North Carolina Council of Community Programs
Area Program Directors
Area Program Board Chairs
Provider Organizations
MH/DD/SAS Professional Organizations and Groups
MH/DD/SAS Stakeholder Organizations and Groups
Other MH/DD/SAS Stakeholders

From: Richard J. Visingardi, Ph.D.

Re: **Communication Bulletin # 011**
***Final* Child Mental Health Plan**

Attached is the final version of the Child Mental Health Plan. This document describes how the Division will provide mental health services to children and adolescents in the state.

The Child Mental Health Plan provides the initial direction for developing a children's system that is most responsive to the lives of children, families and communities. My gratitude goes to the State Collaborative as well as the many individuals, groups and organizations for their leadership and input into the development of this plan. This is indeed a challenging endeavor and the leadership and conversation, including debate, needs to continue as we move forward to implement the vision.

cc: Secretary Carmen Hooker Odom
Lanier Cansler
James Bernstein
Mark Van Sciver
MH/DD/SA Staff

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Child Mental Health Plan

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Tel 919-733-7011 • Fax 919-733-1221 • Courier 56-20-24

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary
Richard J. Visingardi, Ph.D., Director

September 2, 2003

To the Citizens of North Carolina:

Each year, for the past three years, a *State Plan: Blueprint for Change* has been published. These plans provide direction as well as reflect reform as a process-- an evolution. We started out on this venture with a vision and as we acquire greater understanding we become better at describing the vision as well the paths to get there. This Child Mental Health Plan is both an extension and under the umbrella of State Plan 2003.

Taken together, State Plan 2003 and the Child Mental Health Plan have two central key expectations: (1) the people we support and serve are the driving force; and (2) the system must continuously find better ways to support and assist people in achieving their life outcomes. The use of person-centered and person-centered family-focused methods is a process for identifying life outcomes and strategies to support the achievement of the outcomes. This requires us to engage people in a manner to ensure that they are truly the driving force. This requires us to recognize that services are a means to an end, not the end. This requires us to realize that people and their communities have strengths, gifts and opportunities that they bring as potential strategies. This requires that people who we support and serve be provided opportunities to be informed decision-makers. What this all really amounts to is a change in perspective from "us" and "them" to simply "us". It reflects the process that each of us use in order to identify and pursue our life-- through good and bad times, in calm and in storm, with joy and pain.

We are moving toward an outcome driven system-- do we actually effect the ends? The person-centered and person-centered family-focused methods are not an end, but rather a way to identify the ends. Best practice is not an end, however it is intended to provide a "road map"; ways that have shown us how we might best reach the ends. We continuously examine these means to the ends to see if we are doing them right and if they are working. The practice of continuously looking for better ways to reach desired outcomes is what quality improvement is all about. Quality improvement requires us to look at outcomes, data and research, to guide us in continuously finding better ways to get to where we are going.

The Child Mental Health Plan provides the initial paths for developing a children's system that is most responsive to the lives of children, families and communities. We all agree that we love our children. We find great consensus of support in the broad desired outcome to support children and families in such a manner so they may thrive- at present and into the future. We find varying perspectives as to the paths that we should take to pursue this endeavor. One should expect these disagreements, as they will provide the impetus for us to continually examine our paths-- to make adjustments that get us to where we desire to go. We find varying perspectives regarding the speed at which this endeavor should proceed. One should also expect these disagreements as they reflect the diversity of emotions, knowledge and interests. I think most people would agree, however, that we do need to set some

benchmarks that will serve as evidence of movement. We will move in such a manner that does not forsake the considerations of what needs to be in place in order to achieve the benchmarks. This is meant to be an evolutionary change process.

My gratitude goes to the State Collaborative as well as the many individuals, groups and organizations for their leadership and input into the development of this plan. This is indeed a challenging endeavor and the leadership and conversation, including debate, needs to continue as we move forward to implement the vision.

Sincerely;

Rich Visingardi

CHILD MENTAL HEALTH PLAN

Introduction and Overview

The provision of mental health services to children and adolescents is a major component of the mission of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Over the years, the way in which the Division carried out that aspect of its mission was influenced, positively and negatively, by a number of factors such as Carolina Alternatives, "Willie M.", Comprehensive Treatment Services Program (CTSP), Systems of Care, and out-of-home placements, among others. While remnants of these various issues continue to influence how services are provided, there is no coherent philosophy that guides the provision of services to children. As the Division proceeds with mental health reform, we are presented with an opportunity for a fundamental re-examination and overhaul of our approach to service delivery to children and their families.

This Plan seeks to take advantage of the opportunity by developing a system that relies upon evidence and partnerships with families as the basis for service provision. The current system is based on services and funding mechanisms that are not always supported by available research and do not always encourage partnerships. Families will be respected and included as partners in the treatment process and collaboration among child serving agencies will be encouraged and supported. The new design will utilize evidence-based practice to achieve the outcomes families want. North Carolina has laid the groundwork for state and local collaboration through the State Collaborative for Children's Services. Through this Plan we will build the infrastructure to support and maintain these collaborative efforts.

The purpose of this Plan is to provide a framework to address structural, financial, and organizational issues encountered in serving children with mental health disorders and their families. This Plan addresses services for all children who receive publicly funded mental health services, including those who are in residence at state facilities and in other out-of-home placements. The intent of this Plan is to foster the development of a full range of formal and informal services and supports in communities across the state. The thrust of the Plan is to support families in ways that minimize the need for out of home placements. The intent of this Plan is to focus on children with mental health disorders and children with mental health and co-occurring disorders such as substance abuse or developmental disabilities.

The change envisioned by the Plan will be evolutionary. The Division will proceed at a deliberate pace. Some of the current child mental health programs and services that are not considered best practice will not have a place in the newly envisioned service system; however, these services and programs will not be eliminated prior to implementation of new services and supports. Further, no institutional services will be reduced or eliminated until adequate community alternatives are developed.

This Plan should be considered within the context of State Plan 2003. It is the intent of this Plan to build upon the philosophies and goals related to Mental Health Reform that are included in the State Plan. This Plan should be understood within the context of the changing role of Area/CountyPrograms/Local Management Entities (AP/LMEs) (e.g., the focus on serving target populations) and the need for increased collaboration with state and local agencies, consumers and family members.

Planning Process

Nationally, school systems, juvenile justice systems, social services, the medical community and the mental health, substance abuse and developmental disabilities service systems are grappling with ways to serve children with complex, multiple needs with limited, dwindling resources. This is providing the impetus for states to re-evaluate traditional methods of service delivery in which agencies provide services and funding via "silos". Instead, states are engaging in planning efforts in which agencies

collaboratively plan to implement systems of care for children with serious emotional disorders (SED) and their families. In this planning process, the Division recognized the importance of building upon the existing foundation of systems of care in North Carolina; therefore, a planning structure was designed utilizing members of the North Carolina State Collaborative for Children's Services to develop recommendations for a comprehensive children's services plan. The State Collaborative, which has been in existence for over two years, consists of representatives from family groups, juvenile justice, social services, schools, public health, the courts, Division of Medical Assistance, area mental health programs, professional associations, child residential facilities, state psychiatric hospitals, universities, advocacy groups and parents of children with serious emotional disturbance. This group has played a key part in increasing inter-agency collaboration and reducing barriers in serving children with mental health needs.

Initial planning began with the State Collaborative during the third week of April 2003 and continued with six day long meetings through June 17, 2003. The Collaborative was provided fact sheets summarizing characteristics of the population, models for approaching systems planning and research on evidence based practice prior to the first meeting. An external consultant to the Division facilitated the meetings. A Division team added the final specifications and action steps to the work of the State Collaborative.

This approach resulted in the following key components of this Plan:

- Mission, Vision and Guiding Principles
- Iteration of Critical Success Factors
- The Collaboration Necessary to Support the Development of Key Child Developmental Assets
- Recommendations for a Comprehensive Array of Services and Supports
- An Agreement to Decrease Reliance on Restrictive Care Through Service Priorities for Downsizing
- Recommendations for Training Needs Relative to the Service Array
- Prioritization of Outcomes
- The Role of the Collaborative and Families in Monitoring Outcomes
- Recommendations for Communication About the Draft and Final Plan
- An Operational Plan

This resulting Child Mental Health Plan supports the foundation of reform by giving children and families a voice and focusing on collaborative and flexible supports delivered within the life environment of the child. The Plan also addresses the issues and recommendations of the Report of the Surgeon General on Mental Health and the report of the President's New Freedom Commission on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. These issues include building the science basis for treatment, overcoming stigma, improving public awareness of effective treatment, ensuring a qualified supply of providers, using evidence-based interventions, addressing cultural issues, improving access, and tailoring available resources to reduce barriers to effectiveness. The components of this Plan mirror and support the studies mandated by the North Carolina General Assembly in 1995 and 1999, and recommendations in House Bill 1519 and Senate Bill 381. The essential recommendations, which bridge the Surgeon General's Report and previously commissioned studies, include increasing community capacity, decreasing reliance on state operated services, establishing local accountability, establishing "bridge" funding, ensuring consistency and standardization of services state-wide and focusing on the primary consumer through child and family centered plans for supports and services.

The essential components of the Plan which echo goals included in the report of the President's New Freedom Commission on Mental Health include decreasing fragmentation in service delivery, ensuring services are driven by the needs and preferences of children and families, elimination of disparities in mental health care through provision of culturally proficient services, early intervention and prevention and advancing the use of evidence-based practices.

Defining the Discussion: Characteristics and Current Data

Children Served

While there are several studies that provide estimates of the prevalence of mental health disorders among children - ranging from 28 to 20 percent for mild mental health disorders and 5 to 6 percent for serious emotional disorders- North Carolina estimates 10 to 12 percent of the state's children experience serious emotional disturbance (SED). This prevalence rate and definition for serious emotional disorder are cited in the Federal Register, June 1998. The definition of children with serious emotional disturbance (SED) is as follows:

> *Children with a serious emotional disturbance are persons from birth up to age 18, who are currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-IV, that resulted in functional impairment which subsequently interferes with or limits the child's role or functioning in family, school or community activities.*

The North Carolina Office of State Budget and Management estimates that there are 1,964,047 children in North Carolina under age 18 based on U.S. 2000 census data; therefore, the estimated number of children under the age of 18 with SED is between 196,404 and 235,686.

Not all children with SED receive services through AP/LMEs. According to the Great Smoky Mountain Study, an epidemiological study conducted by Burns and colleagues on a North Carolina population of children and their families, 89 percent of children seek mental health services from their primary care provider. Thus connections and coordination with pediatricians and family practice physicians are crucial. The number of children who access AP/LME services reflect that a large number of children with serious emotional disturbance are either seeking private sector services or are unserved. The following table provides a five-year analysis of the number of children with a primary mental health diagnosis who were served through North Carolina's AP/LMEs. Of the estimated 235,686 children with SED, 85,703 children served during State Fiscal Year 2001-2002 accessed services through an AP/LME.

Total Number of Children and Adolescents with a Mental Health Diagnosis Served by Area Mental Health Programs

Year	Number Served
SFY98	76,485
SFY99	78,185
SFY00	64,698
SFY01	74,723
SFY02	85,703

As indicated in State Plan 2003: BluePrint for Change, it is the intent for AP/LMEs to provide core ~~basic~~ mental health services to all children seeking care while providing an enhanced array of services to targeted populations. This Plan addresses the services, financing and organizational issues associated with meeting the needs of the child mental health target populations as delineated in State Plan 2003. The following are the criteria for the four target population groups for children with mental health needs.

Child with serious emotional disturbance who requires out-of-home placement (CMSED)

Child, under the age of 18, with atypical development (up to age 5) or serious emotional disturbance (SED) as evidenced by the presence of a diagnosable mental, behavioral or emotional disturbance that meets diagnostic criteria specified in ICD-9;

AND

Functional impairment that seriously interferes with or limits his/her role or functioning in family, school or community activities as indicated by one or more of the following:

- CAFAS score of at least 90; **OR**
- Total CAFAS score is greater than or equal to 70 and it is determined that appropriate functioning depends on receiving a specific treatment and withdrawal would result in a significant deterioration in functioning; **OR**
- In need of specialized services from more than one child-serving agency (e.g. mental health provider(s) and DSS, DPI/schools, DJJDP, DPH, DCD or health care).

AND

Placed out of the home or at risk of out-of-home placement, as evidenced by any of the following:

- Utilizing or having utilized acute crisis intervention services or intensive wraparound services in order to maintain community placement within the past year.
- Having had three or more psychiatric hospitalizations or at least one hospitalization of 60 continuous days within the past year.
- Having had DSS substantiated abuse, neglect or dependency within the past year.
- Having been expelled from two or more daycare or pre-kindergarten situations within the past year.
- Having been adjudicated or convicted of a felony or two or more Class A1 misdemeanors in juvenile or adult court or placed in a youth development center, prison, juvenile detention center or jail within the past year.
- Situation exacerbated by special needs (e.g. physical disability that substantially interferes with functioning).

Child with serious emotional disturbance (CMMED)

Child, under the age of 18, with atypical development (up to age five) or serious emotional disturbance (SED) by the presence of a diagnosable mental, behavioral or emotional disturbance that meets diagnostic criteria specified in ICD-9;

AND

Functional impairment that seriously interferes with or limits his/her role or functioning in family, school or community activities as evidenced by one or more of the following:

- CAFAS score of at least 60; **OR**
- Total CAFAS score greater than or equal to 40 and it is determined that appropriate functioning depends on receiving a specific treatment and withdrawal would result in a significant deterioration in functioning.

Child who is deaf or hard of hearing (CMDEF)

Child, under the age of 18, who is assessed as deaf or as needing specialized mental health services due to social, linguistic or cultural needs associated with individual or familial deafness or hearing loss; **AND**

The presence of a diagnosable mental, behavioral or emotional disturbance that meets diagnostic criteria specified in ICD-9.

Child who is homeless – PATH (CMPAT)

Child, under the age of 18, who has serious emotional disturbance (SED) and has an ICD-9 diagnosis(es) and is;

Homeless, as defined by:

- Lacks a fixed, regular, adequate night-time residence; **OR**
- Has a primary night-time residence that is:
  (a) Temporary shelter; **or**
  (b) Temporary residence for individuals who would otherwise be institutionalized; **or**
  (c) Place not designed/used as a regular sleeping accommodations for human beings.

OR

At imminent risk of homelessness as defined by:

- Due to be evicted or discharged from a stay of 30 days or less from a treatment facility **AND**
- Who lacks resources to obtain and/or maintain housing.

Where Services are Provided

Currently, mental health services for children are provided in a variety of settings; however, over the past several years there has been an increase in the reliance on facility-based services and restrictive types of care including state psychiatric hospitals, Psychiatric Residential Treatment Facilities (PRTFs), state residential treatment centers and other residential treatment facilities.

During SFY03, the four state hospitals collectively had 1,310 admissions to their child and adolescent units. The average daily census for the four hospitals was 83. Current plans call for a reduction in the number of child and adolescent beds in the state hospitals to 55 by SFY06 and for the elimination of PRTFs in the state hospitals by SFY05. Private providers may continue to develop and operate PRTFs.

The PRTF was added to the continuum of Medicaid-covered services effective October 2000. There are currently 7 private providers that are licensed to offer PRTF services in North Carolina[1]. There are also two state psychiatric hospitals that currently offer PRTF services. For SFY02, there were 333 children served in PRTFs at a cost of $12.4 million in Medicaid dollars. Complete data are not yet available for SFY 03.

There are currently three state residential treatment centers for children and adolescents: Whitaker School, Wright School and the Eastern Adolescent Treatment Program (EATP). Whitaker School is a 36-bed facility that serves adolescents, ages 13-17. The North Carolina General Assembly has endorsed plans that call for the closure of Whitaker School. Wright School is a 24-bed facility and EATP is an 8-bed unit. Upon effective implementation of the community-based services envisioned in the Child Mental Health Plan, it is anticipated that this would lead to the eventual closure of Whitaker School, Wright School and EATP. However, these facilities will not be closed until sufficient alternative services are made available.

Due to changes in residential provider rates and the provider enrollment process, additional community-based residential providers were established in North Carolina during SFY01 through SFY03. In August 2001, there were 148 child residential care providers that housed 1,072 beds.[2] Effective, August 2003, the number of facilities licensed by the Division of Facility Services under 10A NCAC 27G.1300 is 848 with a total of 3,589 beds.[3] While an exact breakdown of type of residential facilities is not known, a majority of these facilities provide Level III residential care. These data indicate a dramatic increase in the number of child residential facilities.

Cost of Services Provided

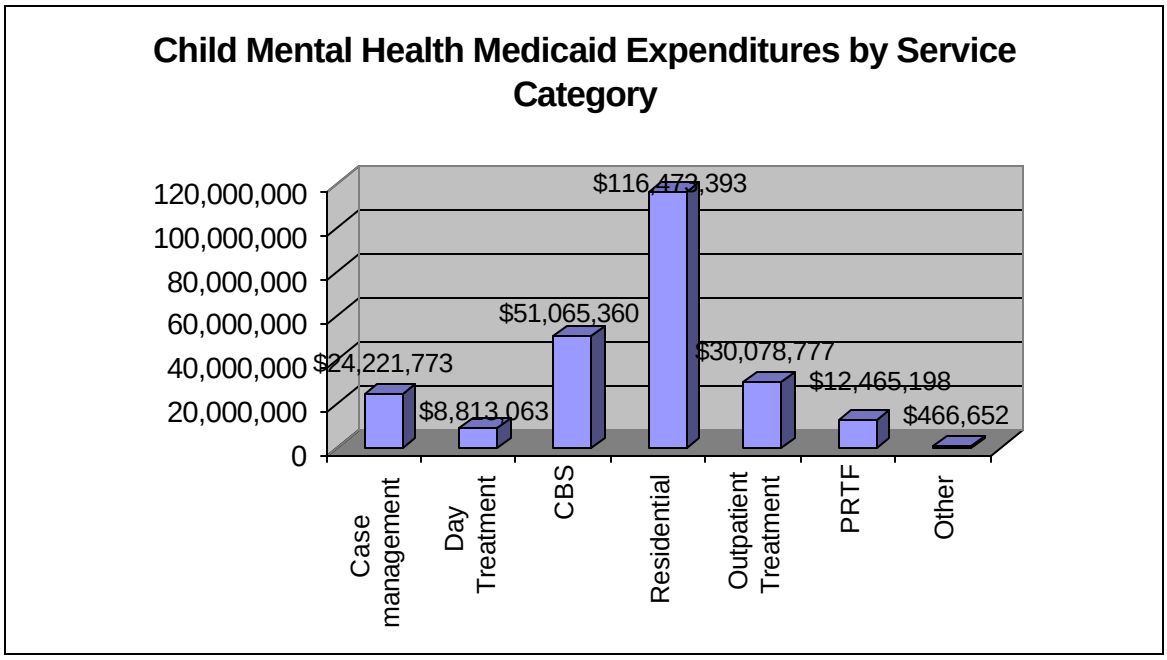
Child mental health services are funded via Medicaid, state and federal funds. For SFY02, there was a total of $69,348,209 in state and federal funds available to support community –based services. State dollars supporting state treatment facilities, including Whitaker School, EATP and Wright School totaled $8,597,761.

Additionally, Medicaid was billed for over $247 million for child mental health services for SFY02. An analysis of Medicaid billing shows that a large percentage of available resources are supporting child residential treatment Levels II-IV. In SFY02 49% ($166 million) of the total child mental health Medicaid

[1] Division of Medical Assistance PRTF Provider Log, effective 8/20/03.
[2] DMH/DD/SAS Child Residential Provider Log, August 2001. Includes Level II, III and IV.
[3] Division of Facility Services Licensed Provider Listing, 8/20/03.

expenditures were for residential treatment. These services were provided to 9% (3,485) of the children utilizing mental health services.

The following chart provides a breakdown of Medicaid expenditures for SFY02 by all service categories presenting a picture of the high cost of child residential treatment. These figures include AP/LME billed services as well as direct-billed services.



Residential care expenditures can be delineated even further. For SFY02, there was a total of $116, 473, 393 in Medicaid expenditures for child residential care. Of that, $85,450,073, (73%) was for Level III facilities, $25,012,156 (21%) was for Level II facilities and $5,042,254 (4%) was for Level IV facilities. This indicates that the majority of expenditures for residential treatment were directed towards Level III residential care.

Expenditure data from the North Carolina Health Choice program provide a similar picture. An April 2003 report to the Commission on Children with Special Health Care Needs indicated that over half (56.8%) of the Health Choice Special Needs Behavioral Health expenditures were for Level III residential services. The remaining expenditures were for intensive case management (15.6%), day treatment (8.2%), other professional services (7.1%), Level IV residential (6.4%), Level II residential (4.0%), and para-professional services (1.4%).

Current System Capacity Concerns

While there appear to be considerable resources available in the child mental health system, there are several mechanisms that prevent access to high quality community-based services that reflect best practices.

- There is currently limited capacity for in-home services. While research indicates that in-home services such as home-based, wraparound and multisystemic therapy promote family preservation and have positive outcomes for children with SED and their families, the current mental health system does not provide funding mechanisms, treatment protocols or training to support these services. Historically, some programs have been supported through grants from

the Division of Social Services (DSS) and the Department of Juvenile Justice and Delinquency Prevention (DJJDP); however, this funding is being eliminated and there are no immediate alternative funding sources available.

- There is a lack of child psychiatrists statewide. A 1999 Needs Assessment of Mental Health Programs prepared by the Area Health Education Centers Program, showed that 51% of Area Mental Health Programs indicated a high priority need for additional child psychiatrists.

- Crisis management and response is inadequate. Findings from the Carolina Alternatives program indicated a need for better crisis response at home and school, a need for in-home up to 24 hour support. Also, crisis management was the worst indicator in the study of NC Families and Children Equal Success (FACES) – a Center for Mental Health Services System of Care demonstration grant site.

- Communities are relying heavily on state psychiatric hospitals and residential placements for the provision of care. Community psychiatrists in North Carolina are emphasizing the use of state psychiatric hospitals due to lack of alternative community based services and supports which would serve to reduce out of home placements. The Division and the North Carolina Hospital Association are working to increase local inpatient psychiatric services for adults and children.

- There are inadequate community resources to enable children to receive a quality assessment before services are initiated.

Planning Framework

The framework for developing the Child Mental Health Plan was created in cooperation with the North Carolina Statewide Children's Collaborative in response to an invitation from the Division. The Collaborative understands the characteristics and needs of children with Serious Emotional Disorders (SED) and the experiences they and their families have while seeking services within the traditional structures of child serving agencies. Multiple child serving agencies, such as mental health, public health, social services, courts, juvenile justice and public schools are responsible for meeting various service needs of these children and families. These service agencies often have separate organizational boundaries and overlapping or conflicting mandates. Families become overwhelmed by the multiple intake procedures, rules and criteria, and sometimes conflicting service plans formulated by different agencies. In addition, traditional agencies tend to rely on professional "expert" assumptions about what children and families should receive rather than responding to what they request. The Collaborative facilitated a process that examined these issues and the desire of the State to create a community based service array that would support a reduced reliance on state hospitals and other levels of residential care.

The following constitutes the framework for the Child Mental Health Plan as established by the Division in collaboration with the State Collaborative, AP/LME and state institution partners. The mission, vision and guiding principles are consistent with the State Plan 2003 and are based on well-researched programming efforts espoused by the Center for Mental Health Services and the United States Surgeon General's Report on Mental Health Services.

Mission

North Carolina will provide children and families with mental health needs a system of quality care, which includes accessible, culturally appropriate, individualized mental health treatment, intervention and prevention services delivered in the home and community in the least restrictive and most consistent manner possible.

Vision

Families, professionals and communities join hands to enable children to be happy, healthy and successful by providing a seamless system of care.

Guiding Principles

1. Families are partners in all aspects of planning, policy, decision-making, service delivery, and evaluation at the state and local level.

2. Families are provided education and support, including peer support, in order to facilitate their partnership role.

3. The system and services are driven by the child and family and their needs and preferences rather than funding.

4. Collaboration is the cornerstone of the system and occurs among the AP/LME, all child-serving agencies, all network providers, family members and other community stakeholders.

5. The system is accessible as evidenced by a comprehensive array of services that are available in a timely manner in geographically convenient locations.

6. The system's quality improvement process is embedded throughout, and includes a focus on functional outcomes, clear standards, accountability measures for AP/LMEs and providers, and inclusion of family members in the quality improvement and monitoring process.

7. The child is conceptualized in a holistic manner. Health, educational, social, recreational and vocational needs are considered along with mental health needs.

8. Education and training occur at multiple levels to achieve a competent fully functioning system.

9. Adequate, flexible resources for all services are available so that funding does not drive the child and family centered plan.

10. Informal services and natural supports are emphasized.

11. Cultural values of families and community norms are honored.

12. A minimum set of services is required across the state and in communities to insure consistency and predictability.

13. Children and their families have access to quality services based on best practice models and evidence-based treatment methods provided by qualified caregivers.

14. The system promotes continuity of services for children as they transition between providers or move into adult services.

15. Prevention and early intervention services are emphasized.

16. Familial bonds are respected and protected. Families should not have to give up custody of their children in order to obtain appropriate services.

Critical Success Factors

Critical success factors are key strategies that, when achieved, propel the system toward attainment of its vision. Each factor is of equal importance and all factors must be focused on simultaneously to be effective. These factors form the basis for the Division's specification of action goals in the operational component of this Plan. These seven factors must be attended to in order to achieve positive change in the child mental health system. These factors provide guidance to state and local agencies for all activities related to serving children.

RESOURCES:
- Maintain existing funding while shifting the use of those funds away from restrictive modes of care.
- Create a flexible pool of funds to be utilized locally for PCPs.
- Informal, community and natural supports are accessed before using or simultaneously with the use of public services.
- Communities develop directories and means for accessing community and natural supports.
- Communities coordinate existing resources and services including early intervention services.
- Early intervention and prevention activities should be funded and promoted.
- Local agencies begin to explore shared funding.

COMMUNICATION:
- Marketing, education and training of families in rights and responsibilities must be done at the local level.
- The Legislature, general public, local officials and key agency staff must be educated to understand the Child Mental Health Plan.

PARTNERSHIP WITH STAKEHOLDERS:
- Involve the state and local collaboratives in Continuous Quality Improvement (CQI) efforts with at least 50 percent of participants as families.
- Provide training and supports for families to participate in a meaningful way.
- Create other mechanisms for families and other stakeholders to be involved in monitoring outcomes.
- Train other stakeholders in the Plan.
- Encourage community capacity building such as neighborhood resource centers, parent skills training carried out in variety of locations expand community safety nets, address transportation issues, and provide conflict resolution training.
- Work to establish process through which training and consultation is provided to primary care physicians on child psychiatric/medication issues.
- Work with communities to ensure each child has a medical home[4].
- Public Health education includes mental health and parenting education.
- Explore opportunities for the Division to partner with State Collaborative member agencies.

BEST PRACTICES:
- Define a minimum required statewide set of services with written standards.
- Implement and monitor a policy for least restrictive care.
- Adopt best practices that demonstrate cultural proficiency [5].

[4] A medical home is defined by the National Center of Medical Home Initiatives for Children with Special Needs as child medical care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent.

[5] As described in State Plan 2003, culturally proficient systems acknowledge and respect the scope and breadth of diversity that characterizes contemporary society. People who identify themselves with a particular ethnic, cultural or religious grouping have established cultural norms or practices such as customs, language, symbolism, rituals and social or behavioral expectations. Cultural competence means that these cultural norms are recognized,

- Conceptualize children holistically.
- Consider family, community and cultural values in establishing the service array.
- Provide training to the AP/LME, providers, families and other child serving agencies such as local schools, local child welfare agencies, local health departments and local children's developmental agencies.
- Recruit competent and qualified providers.
- Create policy and criteria for development of the PCP.

ACCESS:
- Establish convenient locations and monitor timeliness standards.
- Create one screening application available for use by all agencies and provide training on the use of the screening application and the process for accessing services.
- Establish gate keeping for entry to restrictive care.
- Recognize that there is a set of required minimum services for consistency statewide.
- Ensure that there is specialist availability to assess target populations with high needs.
- Provide outreach to and in schools, courts and children in foster care.

ACCOUNTABILITY:
- Establish outcome measures and benchmarks.
- Functional outcomes are designed with input from stakeholders.
- Establish process for collecting evaluation data.
- Clarify CQI expectations in contracts and MOAs.

MEMORANDA OF AGREEMENT:
- State Divisions and Departments establish policy regarding collaboration and interagency responsibilities.
- All state contracts and MOAs include the requirement for Collaboratives.
- Local Collaboratives develop agreements within communities.
- Statewide training is provided in development of agreements at the local level.
- All agreements must minimally include continuity of service agreements, no eject/no reject agreements, families as partners, parental support mechanisms, and who pays for the service.

Summary of Agency Responsibility to Support Developmental Assets

While responsibility cannot be assigned to other agencies through this Plan, there is clear agreement as to the importance of the support of the entire community and its public agencies in assuring the development of assets that ultimately create a healthy, responsible adult capable of giving back to a community.

As conceptualized in this Plan, developmental assets for children birth to five years old include:
- A Safe Home
- A Loving Caregiver
- A Stimulating Environment
- Healthy Beginnings And Development
- School Readiness By Age 5

Developmental assets for children and youth age 6-18 include:
- A Safe Home

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accommodated and respected. Culturally competent systems, both management and provider, acknowledge and demonstrate appreciation and respect for human diversity.

- Caring Adults
- School Success
- Positive Peer Relationships
- Healthy Behaviors
- Opportunities To Give Back

To accomplish these objectives, interagency collaboration is crucial. Such interagency collaboration shall:

1. Provide early identification and assessment incorporating use of screening tools for newborns.
2. Provide access to services through one application to an array of services.
3. Provide outreach to schools, police, and families involved with other agencies as well as home visiting programs.
4. Provide early intervention that incorporates developmental education, parenting training and a mental health screening in a variety of settings.
5. Identify and support a strong adult role model for every child.
6. Support family partnerships with agencies.
7. Build community capacity for families to care for each other.
8. Coordinate existing early childhood programs.
9. Provide agency and peer supports for parents so that they can maintain the adult role in the family.
10. Seek safe, affordable stimulating childcare with subsides, as necessary.
11. Provide information and referral to services and informal supports in a variety of manners.
12. Aid families in obtaining needed resources to meet their basic needs.
13. Provide education and work skills training for parents.
14. Provide children multiple paths to success, including vocational education.
15. Support the expansion of and greater availability of supervised after school activities.
16. Partner with families and Mental Health to identify children at risk earlier.
17. Collaborate to avoid children being ejected or dropping out of school settings.
18. Make available primary family health and wellness education.
19. Be proactive in community planning for children and families.
20. Teach and encourage adult caregivers to practice healthy behaviors and assume caring adult roles and responsibilities.
21. Encourage families to participate in treatment and actively use supports and resources.
22. Involve families in policy making and planning for effective services for children.
23. Promote “problem solving courts” where judges are trained to expect effective integrated services for children and families.
24. Develop safe, affordable housing.
25. Expand community safety nets through community watches.
26. Provide reliable, safe and affordable transportation to access care.
27. Develop community/neighborhood centers with family supports.
28. Identify community resources to support families.
29. Provide a safe place for children to learn developmentally appropriate behaviors through a variety of activities and choices.
30. Provide social educational, recreation and vocational activities to teach responsibility, leadership and the ability to work together.
31. Provide opportunities for healthy peer interaction.
32. Engage in proactive community planning to address child and family needs.
33. Support accessible, affordable medical care.
34. Explore funding strategies that ensure efficiency and support pooling of resources among agencies.
35. Ensure a medical home for each child.
36. Increase access to health care- primary, dental, vision screening.

37. Provide conflict resolution and social skills training for children and youth in collaboration with other agencies.
38. Encourage and support males as caregivers.
39. Educate decision-makers regarding child mental health needs and systems of care.

Envisioned Service Array

As delineated in the State Plan 2003, AP/LMEs will have responsibility for authorizing a plan of services to meet the needs of the child and family. This Plan stresses the importance of AP/LME following best practice protocols in providing services and supports. As defined in State Plan 2003, best practice services and supports "are well implemented, scientifically defensible, supported by formal evaluation and research, have documented evidence of significant consensus among experts in the field, and have demonstrated effectiveness and positive outcomes for consumers and their families." This Plan uses this definition for best practice services and supports.

The following section regarding the envisioned service array is organized in the following manner:
a) five broad service categories (Assessment and Diagnosis, Community Inpatient, Inpatient Alternatives, Community Living Services, and School Based and Vocational Services) which contain specific service descriptions;
b) a partial listing of therapeutic modalities that are best practice or emerging best practice for specific child mental health sub-populations;
c) a list of services that are to be provided collaboratively with other child-serving agencies; and
d) a crosswalk of envisioned services to the current child mental health service array.

SERVICE DESCRIPTIONS

Assessment and Diagnosis

Assessment and Diagnosis

Description:

Generally accepted professional assessments or tests, including psychological tests or specialized outpatient assessments that are conducted for the purposes of determining level of functioning and treatment needs of the individual. Specialized outpatient assessments may include sex offender specific evaluations, forensic, substance abuse, and sexual abuse/trauma evaluations. These also include psychosocial, developmental, and vocational assessments.

Appropriate for:

- Children with suspected or established emotional disorders that are seeking services from the AP/LME.
- Specific assessments are determined based on age, cognitive presentation, symptom presentation and the specific service to which the child is seeking admission.

Amount and Duration:

- Assessments are authorized annually or when there is a significant change in condition. A child may need more than one assessment to establish strengths and issues for person-centered planning. The specific reason for the assessment is required.
- Assessments more than one year old require documentation of suspected changes in condition.

Psychological Testing

Description:

Psychological testing includes standardized intelligence, personality, or neuropsychological tests rendered by licensed psychologists or licensed psychological associates. The child's clinical record must indicate the name of the person who administered the tests, and the actual tests administered. The protocols for testing must be available for review. Psychologists are expected to follow best practices and to administer and interpret psychological tests in a competent manner that would report findings which accurately reflect the assessment data.

Appropriate for:

- Child who is not responding to recommended treatment and/or diagnosis is in doubt.
- Child who is age 17 or younger, with a suspected ADHD diagnosis, referred for psychotropic medications.
- Child for whom guardianship has been requested.
- Child who is experiencing a deterioration of cognitive function with suspicion of a recently acquired or traumatic brain injury.

Psychiatric Evaluation

Description:

A comprehensive evaluation, performed face-to-face by a psychiatrist, that investigates a child's clinical status including the presenting problem; the history of the present illness; previous psychiatric, physical, and medication history; relevant personal and family history; personal strengths and assets; and a mental status examination. This examination concludes with a written summary of positive findings, a bio-psychosocial formulation and diagnostic statement, an estimate of risk factors, initial treatment recommendations, an interpretation of findings and recommendations to the parent or guardian, an estimate of length of stay when indicated, and criteria for discharge.

Appropriate for:

- Child with a suspected diagnosis of an emotional and/or behavioral disorder and community resources or a community-based physician cannot meet consumer need.
- Child who is not currently able to use community based physician to provide stabilizing medication regimen.

Amount and Duration:

- An annual evaluation.

Psychiatric Medication Review

Description:

This service includes evaluating and monitoring medications, their effects, and the need for continuing or changing the medication regimen. The medication review may result in the prescription of medications including the assessment of current prescribed medications for safety and efficacy and the coordination of medication orders among all involved providers. The service includes an assessment of the medication's desired effect; current orders evaluated in all care settings; and coordination between the physicians, pharmacy, and care settings.

Appropriate for:

- Child who is diagnosed with a serious emotional disorder for which medication is an effective treatment per accepted standards of practice.
- Child's medication oversight cannot be met by community resources.
- Children must have a primary clinician unless the following criteria are met for "meds only".
  - Crisis-free for 1 year.
  - Compliant with physician appointments.
  - Compliant with primary mental health provider appointments.
  - Stable on current medications for at least 6 months.
  - Child and Family Team agrees with a transfer to community physician.

Also, appropriate when:

- Physician does not feel comfortable supervising the administration of medication prescribed by a community physician.

Amount and Duration:

- Authorized at least quarterly for physician's medication review.

Community Inpatient

Community Inpatient

Description:

Local or state inpatient psychiatric services are designed for children experiencing an acute psychiatric crisis. Screening services include determining whether inpatient or alternative services are the most appropriate. Screening services are provided face to face. Screening is provided in a manner that maximizes consumer involvement and engagement. This includes conducting inpatient screening in community settings. Screening shall assure that children are provided least restrictive treatment and diverted to inpatient alternatives when clinically appropriate. This service is available at all times (24 hours a day/7 days a week). Service in the inpatient setting includes a comprehensive array of services provided to adequately treat acute psychiatric illnesses, including, psychiatric evaluation, enhanced health services, medication stabilization, and discharge planning through person-centered planning teams. It is short term, and the goal is to stabilize the child and return the child to community supports and home as soon as possible.

Appropriate for:

- Child who is a danger to self and/or others or unable to care for basic needs due to SED. This may be exemplified by one of the following:
  - Child is not appropriate for less restrictive service due to safety concerns.
  - Child needs 24 hour supervision and less restrictive settings have been attempted or found ineffective at resolving/managing the acute symptoms.
  - Child needs a locked setting to ensure safety.
  - Functioning has decompensated, consumer/family does not recognize need for mental health treatment, and there is risk for further serious health safety risks.
- Child who has been placed on a combination of medications that cannot be safely titrated in the home or an alternative setting, even with the use of in-home nursing and monitoring.

Amount and Duration:

- Less than 2 weeks.
- Less restrictive services/inpatient alternatives may be authorized to shorten the length of stay.

Specialized Diagnostic Evaluation Unit

(10 beds statewide for ages 12 and under)
(10 beds statewide for ages 13-17)

Description:

Structured inpatient treatment and support activities provided in a unit in a hospital setting designed to provide short-term, intermediate or complex diagnostic and assessment service that cannot be performed outside a hospital setting. This may include assessments, stabilization on medication, and the initiation of a behavioral plan. Services are intensive treatment interventions delivered by an intensive assessment and stabilization treatment team, under psychiatric supervision. Service components include: intensive trauma therapy; assessments rendered by the treatment team including the psychiatric assessment; behavioral assessment and other testing; family support and planning; psychiatric supervision and medication review; and nursing services/consultation. A written plan must be in place that addresses medication issues and

health and safety needs; specifies supervisory needs; includes training for the family in implementing the behavioral plan in the home; and includes discharge planning.

Appropriate for:

- Child age 17 and under with SED.
- Child who has multiple impairments, co-morbid conditions that are not commonly seen or easily treated with typical combinations of psychotropics and/or therapeutic interventions.
- Child requiring short-term and thorough specialist evaluation, medication stabilization and supervision to remain safe from self-harm.
- Child who can benefit from short term, intensive treatment and specialist evaluation to allow for the development, training of caregivers/family, and implementation of a home/community management plan.
- Child who is medically stable. A written review by a registered nurse is required prior to admission. Vital signs must be evaluated and must be within normal limits, as well as, major medical history conditions such as a cardiac condition, history of head trauma, substance abuse, diabetes, etc.

Amount and Duration:

- Short-term (2 weeks).
- Intermediate (4 to 8 weeks).
- Complex (3-4 months) with possible extension of up to 4 months when home trials of the management plan have failed.

Inpatient Alternatives

Crisis Residential or Residential Treatment Center

Description:

Inpatient alternatives of intensive therapeutic services that provide short-term care for children experiencing an acute psychiatric crisis. Services are intended to avert a psychiatric admission, or to shorten the length of an inpatient stay and are designed for a subset of children who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately serviced in a setting less intensive than a hospital.

Appropriate for:

- Child requiring continued 24-hour supervision to avoid inpatient stay or to shorten the length of an inpatient stay as a result of a serious emotional disorder.
- Child requiring short-term medication stabilization and/or supervision to remain safe from self-harm.
- Child requiring 24-hour supervision to maintain safety needs.
- Child who is re-directable and can safely be supervised in an unlocked setting.
- Child who is medically stable. A written review by a registered nurse is required prior to admission. Vital signs must be evaluated and must be within normal limits, as well as, major medical history conditions such as a cardiac condition, recent history of head trauma, diabetes, etc.

Amount and Duration:

- A maximum of 14 days.

Community Living Services

Home-Based Services

Description:
Intensive therapeutic services to individuals and families with multiple service needs that require access to a comprehensive array of mental health services. Services are intended to promote normal development, promote healthy family functioning, support and preserve families, reunite families who have been separated, and reduce the usage of, or shorten the length of stay in, psychiatric hospitals and other substitute care settings. The family unit is the focus of treatment, support and education. This is a bundled service that includes supervision, intervention, coaching and crisis management. This is a time limited intensive family preservation intervention intended to stabilize the living arrangement, promote reunification or prevent the utilization of out of home therapeutic resources (i.e. psychiatric hospital, therapeutic foster care, residential treatment facility) for the identified youth. These services are delivered primarily to children in their family's home with a family focus to:
1) diffuse the current crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence;
2) ensure the linkage to needed community services and resources;
3) provide self help and living skills training for youth;
4) provide parenting skills training to help the family build strengths for coping with the child's disorder;
5) monitor and manage the presenting psychiatric and addiction symptoms; and
6) work with caregivers in the implementation of home-based behavioral supports.
Services may include crisis management, including in-home intensive case management and in-home crisis management, individual and/or family therapy, substance abuse intervention, domestic violence counseling services, parenting skills training, individual skills training, and other rehabilitative supports to prevent the need for a out of home, more restrictive services. This team approach is structured face–to–face therapeutic interventions to provide support and guidance in all areas of functional domains including adaptive, communication, psychosocial, problem solving, and behavior management. This service includes interventions that address the functional problems associated with the most complex and/or pervasive conditions of the identified population. These interventions are strength-based and focused on promoting youth and family stability, increasing the youth's and family's ability to cope and relate to others, and enhancing the highest level of functioning in the community.
Appropriate for :

- Child who has a diagnosis of SED **or** for Infant Mental Health (IMH), the parent must have a diagnosed mental illness or developmental disability **and** the family must have multiple risk factors as described below:
  - Child who has needs that require at least two contacts a week.
  - Child who is at risk for out of home placement or is in an out of home placement and reunification is imminent.
  - Family needs intensive interventions to preserve family unit.
  - Child's behavior problems cannot be managed using Outpatient Services or Case Management.
  - Child has problems across settings
  - The child and/or family have insufficient or severely limited resources or strengths necessary to cope with an immediate crisis.
  - The youth and/or family issues are unmanageable in school based on behavioral program settings and require intensive coordinated clinical and positive behavioral interventions.
  - Repeated attempts at other less restrictive types of services have not been effective.

Amount and Duration:

- Services are provided in the family home, school and community.
- Documentation of the child's ongoing risk for out of home placement is required.
- Documentation of the specific psychiatric symptoms and family issues to be addressed during the requested period is required for initial authorization.

- An assessment of the family's progress to date including identified barriers if progress is less than expected.
- An anticipated aftercare plan including time frame and suggested aftercare service must be completed at onset of service.
- Duration: 6 months to one year; extensions may be approved up to three months with substantial evidence of progress toward outcomes.

Independent Living Services (Homelessness or Transition)

Description:

Independent Living Support Services (ILSS) is designed to provide a seamless array of services to children that have significant housing needs in addition to needs for case management and training. This service includes necessary efforts to obtain housing, obtain resources for housing, and to maintain housing. Agencies providing this service are expected to be involved in developing and identifying housing options in the community and must be well versed in available housing subsidies and how to advocate for consumers for these resources. Coaching is utilized to develop independent living skills including budgeting, cooking, housekeeping, relationship development skills, leadership skills, vocational skills and other responsible adult behavior. Additionally, support is provided to assist the young adult in seeking a high school diploma or GED.

Appropriate for:

- Youth, age 16 or older.
- Youth who is Severely and Persistently Mentally Ill (SPMI), **or** SED.
- Youth who has housing support needs such as need for more independent housing, inability to retain current (appropriate) housing, currently in sub-standard housing, inability to coordinate housing resources, etc.
- Youth who meets basic eligibility criteria for case management.
- Youth who is likely to increase independence and use of natural/community resources through use of this service.
- The family is unable to meet the identified need.
- Youth who is in a licensed setting with independent living goals and transition plan in place.

Amount and Duration:

- The ongoing services may be authorized up to one year. Additional services are appropriate only if there is progress toward independence and reduction in paid supports.

Services in Therapeutic Foster Care and Group Home Settings

Description:

Specialized mental health foster care is a range of assistance that enables children to accomplish tasks they would normally do for themselves if they did not have a Serious Emotional Disorder. Specialized mental health care in these settings, as an additional service, requires that the child have needs that require a more intensive level of care than basic services of a licensed home, of a DSS placement or of a juvenile detention facility. Intensity of child need and the family and child centered outcomes addressed must be evident. Permanency planning inherent in this function must address post adoption services (if adoption is part of the permanency plan) that include, therapy for the child around loss and identity or any neglect and abuse issues, parental support, education for the new family regarding child developmental and cultural issues (specifically for international adoptions). The service also includes a focus on shared parenting to address parental fear and control and boundary issues. Education is also provided to caregivers regarding mental illness and substance abuse issues. Specific services may include the following:

- Assistance/support with food preparation, clothing, laundry, and housekeeping beyond the level required by facility licensure (including training in shopping, food preparation, managing laundry, home management which is aimed at increasing the child's ability to manage in a more independent living situation) or contributing to family chores.

- Training in compliance or self administration of medications.
- Health management, including medication management (training and other interventions beyond medication administration) and delegated medical treatments and health management activities.
- Personal relationship establishment/maintenance/opportunities for social activities.
- Leisure activities that are specified in the person-centered plan to meet individualized outcomes.
- Promotion of personal/community safety (including behavior management, training in adaptive behaviors, safety training, etc.).
- Increased use and independence in the community, including training in use of community resources.
- Specialized supervision under specific circumstances over and above that required and expected for any foster care setting. Examples include elopement risk supported by recent history and current behaviors indicative and conducive to elopement; consumer at serious risk for harming self or others if unsupervised, supported by recent history and current behaviors indicative of and conducive to this; medical problem that can become life threatening quickly without monitoring due to SED.
- Reunification and transition back to the home.

Appropriate for:

- Child with SED.
- Child must reside in a licensed residential setting.
- Child/family must have a case manager to plan for reunification. The case manager may be from another system.
- Child must display significant deficits in personal care, and/or behavioral control that require ongoing supports above what can be provided in a home setting. Examples are intensive applied behavioral interventions and/or intensive supervision to maintain child's health and/or safety. The PCP must detail what will be done to decrease or eliminate the need for personal care service, including efforts to return the child to the home and to seek natural/community supports.
- Child's personal care services must address outcomes specified in the PCP. Examples of areas to be addressed may include grief work, coping skills, loss and separation, anger management, peer relations, family strengthening and support for remedial education.
- In home supports are inadequate for meeting the consumer's personal care needs.
- The discharge plan must be completed at admission and the family must be involved in reunification efforts.

Amount and Duration:

- The PCP must describe the rationale for enhanced supervision.
- Services that cannot be met in the home or through natural/community resources or basic care as described above include behavior management for unexpected problems, as well as expected problems that are documented in the treatment plan.
- The child must be reasonably expected to move home or to a more independent setting within 6 months. Extensions may be granted up to 3 months for modifications in failed reunification attempts but must incorporate parental involvement, a discharge plan in place or a plan for permanency to be effected within 6-9 months but may be extended in the best interests of the child.
- Children's services are authorized if all other attempts at in home services and supports have failed.

Case Management

Description:

Services that will assist children and families in gaining access to needed entitlements, medical, social, educational and other services. Core elements of case management include assessment,

development of a child and family centered plan of service, linking/coordination of services (including network, community and natural support services), re-assessment/follow-up, and monitoring of services to ensure they are provided according to the PCP and desired outcomes are achieved. Monitoring of services includes all services in the Plan, which may or may not be provided directly by the assigned case manager. Case managers are also required to find and secure placements for children. Face to face contacts with the enrolled child and family must occur at varying frequencies based on the level of care needed. Case Management is provided to children and families who have an array of services and is required for children in licensed residential settings.

Appropriate for:

- Child with SED.
- Child needs a variety of natural and community based supports, and/or receives multiple services, needs assistance in coordination of those services, and cannot manage this with their family or independently or through the use of natural and community supports; **and/or**
- Child and family have chronic manifestation of problems with limited success in management of those symptoms; **or**
- Child requires "step down" from a more intensive service such as mental health home based services; **or**
- Child behavior routinely decompensates, resulting in regular need for crisis intervention services; **or**
- Child has financial and/or benefit management problems and requires assistance in managing them; **and**
- Family, natural and community supports are unable to meet the child and family need.

Amount and Duration:

- One year or more as needed.

Wraparound Services

Description:

Wraparound is the delivery of direct, hands on intensive intervention and family preservation services to families and children. The child (ren) and family must have intensive needs involving multiple community systems and services. Service interventions may include frequent/intensive family contact, assessment, referral and coordination to and between other agencies/service providers, and development/ identification/use of community resources and natural supports. Services may be provided by a single clinician or a variety of professionals and paraprofessionals based on needs described in the PCP. Services may include all or a portion of the following: participation with the child and/or family in community activities; coordination with schools, the court system, the police, the public health and health care system, and other agencies; liaison between the child and/or family and needed community resources; providing positive role models; performing related activities as outlined in the PCP. Behavior Treatment Plan implementation may include coaching and assisting parents, teachers and school personnel, emergency response to family and school crises, and participation with the family and/or child in community activities as defined in the Behavior Treatment Plan. Financial assistance to cover personal emergencies including security deposits, first month rent, assistance paying back rent, utility and moving expenses, up to 14 days of emergency shelter and other housing related emergencies if needed through flexible funding to support needs in the PCP. Non-financial assistance including but not limited to assistance with landlord negotiations, locating appropriate housing options, referrals to appropriate community resources, referral to appropriate health and mental health programs and help locating food, clothing, transportation and shelter is also a function of this service.

Appropriate for:

- Child referred is 17 years of age or younger.

- Child has a diagnosis of SED or less severe emotional disorder with significant functional/behavioral/cognitive/medical deficits.
- Child has involvement with multiple community agencies.
- Child has treatment needs that exceed the scope of treatment by other intensive treatment modalities.
- System concerns about parenting exist which require extensive monitoring and training.
- Child has behavioral problems which require close supervision for safety of child/others.
- Behavioral Treatment Plan is in place which requires family training and role modeling for implementation.
- Parents are unable to manage child in the home without assistance.
- Child is at risk for out of home placement.
- Natural and community resources have not been effective in providing support to the family.
- Other natural and community supports and involved agencies agree to participate in the service delivery through a coordinated plan that shares resources.

Amount and Duration:

- Services are provided in the family home, school and community.
- 6 months to one year, as needed.
- Typically, this service should be provided one on one with the Child and with the family unit for training and support. This includes behavior management for unexpected problems, as well as expected problems that are documented in the PCP.
- Intermittent one time expenses.

Family Support Services

Description:

Education and support for families (parents, spouse, siblings, children, relatives and other caregivers) who are caring for, or who regularly interact with, a family member who has a mental illness or serious emotional impairment. Education includes information about disorders and their development, treatment options and regimens, as well as use of medication, and management of crisis situations, etc. Family support can be defined as facilitating access to a contact person, mentor, help line, support group or family advocate to strengthen families through education and skill development. Examples of skills development includes:

- Use of assistive technology.
- Problem solving skills.
- Self care.
- Communication skills.
- Stress and anger management.
- Behavior management plans, including positive reinforcement.
- Client rights.
- Consumer choice.
- Best practices.
- Parent training, including child management skills training.
- Child and Family Team training.
- Advocacy skills.

Appropriate for:

- Family members, caregivers and significant others of children diagnosed with SED.
- Natural/community resources are not adequate to meet the educational need.

Amount and Duration:

- Intermittent, episodic for specific outcomes in the PCP.

Respite Care

Description:

Respite care includes services that are provided to children unable to care for themselves on a short-term basis and whose unpaid primary caregiver or therapeutic foster home parent requires relief. The service should be delivered during the time of day when the caregiver normally provides care. Respite programs can use a variety of methods to achieve the outcome of relief from care-giving including family friends, trained respite workers, foster homes, residential treatment facilities, respite centers, camps, recreational facilities, etc. Respite care, when predictable, should be agreed to and outlined in the PCP giving credence to caregiver and consumer choice about the type, amount and duration of respite necessary to prevent more restrictive placement. Active clinical treatment should not be required as a prerequisite for receiving respite care. Respite coordination should be a care coordination service under the AP/LME to enable families to locate providers. Respite services are not intended to substitute for the services of paid support-training staff, crisis stabilization, and crisis residential treatment or out-of-home placement. Services may be provided in the home or out of home but cannot include the costs of room and board. Payment cannot be made to a responsible relative for the care.

Appropriate for:

- Child is living in a private residence with primary caregiver present.
- Child cannot be left unsupervised for more than short periods of time without potential for serious health and/or safety risks.
- Child with SED.
- Primary caregiver needs relief from providing care to prevent more restrictive service or placement.
- Child's needs cannot be met by natural/community resources.

Amount and Duration:

- Services may be requested as needed for short-term periodic needs, or may be requested for longer periods if necessary, such as the hospitalization of the caregiver, etc.
- Respite services are temporary and/or periodic care taking services aimed at providing relief to regular caretakers so that more restrictive placement or services can be avoided.
- Respite is not authorized as a “day care” service to enable parents to work.
- For a child in therapeutic foster care, the foster home parent may not receive payment for services at the same time the child is in respite care.

School Based and Vocational Services

School Based Services

Research suggests that schools often function as the de facto mental health system for children and adolescents (Burns et al., 1995). Research has also shown that nearly half of all schools contract or make other arrangements with a community-based organization to provide mental health or social services to students (Brenner et al., 2000). There are many opportunities for APs/LMEs to work collaboratively with schools. For example, many of the services included in the envisioned service array can be provided in a school setting. Specific examples include home-based services and wraparound services. Additionally, federal school mandates may provide provisions for schools to work collaboratively with local mental health agencies. For example, a number of provisions included in the No Child Left Behind Act (NCLB) provide discretionary grants or allow funds to be used to expand school-based mental health services and improve coordination of services with other child-serving agencies. In addition, the following services can be provided in school setting.

Transitional Services For Skill Building

Description:

Skill Building services are designed to assist individuals in acquiring, retaining, and improving self-help, communication, academic and adaptive skills necessary to achieve gainful employment. The service may be school based to increase attendance and functioning in the school environment or Pre-vocational or Supported Employment.

Prevocational services: Prevocational services are aimed at preparing the individual for paid or unpaid employment. It includes teaching such concepts as attending, task completion, problem solving and safety. Prevocational services are provided to people not expected to enter the workforce within one year. Prevocational activities cannot be directed at teaching skills that are specific to a particular job. Person-centered outcomes for prevocational services cannot be employment related. If the consumer is ready for employment related goals and specific job skills, the supported employment requirements in the next paragraph must be met.

Appropriate for:

- Child has a Serious Emotional Disorder or a Severe and Persistent Mental Illness.
- Child with less severe emotional disorder or mental illness when DPI or VR are providing services and coordination is necessary with the mental health system over a two to three year period for transition purposes.
- Consumer is exiting the child system within the next year.
- Consumer would be reasonably able to accept supported employment within 3 months following the mental health transitional service.
- Child has a case manager.
- Natural and/or community supports are not able to meet this need.
- Child has identified work as an outcome in the PCP.

Amount and Duration:

- Prevocational Skill Building cannot include costs of routine supervision that is the responsibility of an employer.
- Prevocational Skill Building cannot pay for subsidies except as provided by the employer (EAP) or through TANF/Work First programs.
- Prevocational Skill Building does not cover the costs of accommodations that the employer is responsible to provide under the ADA.

Supported Employment

Description:

Service is intended to coordinate vocational rehabilitation services to young adult consumers who have physical and/or mental disabilities, which constitute a substantial impediment to employment. Supported Employment is a service that assists individuals, age 16 and older, with a mental illness and/or a mental illness and a co-occurring disorder (SA and DD) to choose, find and keep competitive employment (community jobs paying at least minimum wage). Supported employment staff carry out all related functions including engagement, assessment, job placement, on-going job support and on-going coordination with all other service(s). The service includes intensive involvement of staff working with the individual in the work setting. There is a work skills focus (interviewing, traveling to and from work, time management, getting along with co-workers, and responding to supervision). There is also emphasis on benefits and any accommodations required by the job.

The services are to prepare for, obtain and maintain employment. Covered services should be provided as a joint agency program to include:

- Transportation needs
- Clothing needs
- Equipment needs
- Trade school/training needs
- Vocational testing
- Employer reimbursement of training wages
- Job development

- Job coaching
- Psychological testing
- Other supports as needed

The supported employment program provides the following:

- Competitive employment rather than transitional, temporary, or sheltered;
- Rapid job searches that don't require a participant to complete long evaluations, work adjustment, etc.;
- Jobs tailored to the individual preferences and skills;
- Time unlimited follow along supports such as weekly "check-ins";
- Integration of supported employment and mental health services
- Zero exclusion criteria, that is, no one is screened out because they are not ready for employment.
- There should be a supportive relationship between the provider and the recipient through whom a variety of services may be implemented according to the employment needs of the individual as identified in the vocational plan. These services include assistance in selecting a job, functional evaluation, assistance in finding/securing a job; on the job support, assistance, and training; and counseling about benefits.
- This service focuses on work schedules that are most accommodating for the individuals and coordination with other services that are assisting in other life domains, social or housing opportunities for example. This is a learn-by-doing service that includes regular, in vivo feedback. When there is a specific behavioral or skill deficit, the vocational staff may make referrals to other providers or may seek the consultation of other providers in managing the deficit.

- This service provides on-going support and supervision on the job site and may also include work related supportive interventions outside of the work environment, in coordination with other providers.

  Appropriate for:
  - Consumer is transitioning to the adult system and has a Serious Emotional Disorder or Mental Illness.
  - Consumer has vocational deficits, identified through the person-centered planning process, that can reasonably be supported by the services provided by this program
  - Individual verbalizes desire to work;
  - Individual has an established pattern of unemployment or sporadic employment;
  - Individual requires assistance to obtain employment and/or requires assistance in addition to what is typically available from the employer to maintain competitive employment.
  - Consumer need cannot be met by community or natural resources

  Amount and Duration:
  - Six months to one year based upon needs in the PCP with evidence that progress is being made toward outcomes.

THERAPEUTIC MODALITIES

Within the envisioned array of services, it is anticipated that practitioners will utilize a number of evidence-based or emerging best practice therapeutic approaches. The following constitutes a partial listing of these evidence based and emerging best practice therapies or modalities for specific child mental health populations. This list is by no means exhaustive but is included as a means to encourage practitioners to utilize evidence-based or emerging best practice therapies in serving children with SED. Additionally, as a part of a Continuous Quality Improvement process, other evidence based and emerging best practice therapies will be added to this envisioned array.

Multisystemic Therapy (MST)

Description:

MST is a program designed to enhance the skills of youth and their families who have anti-social, aggressive/violent behaviors; are at risk of out-of-home placement due to delinquency; are adjudicated youth returning from out-of-home placement; are chronic or violent juvenile offenders; and/or are youth with serious emotional disorders involved in the juvenile justice system (Henggeler, Schoenwald, Borduin, Rowland & Cunningham, 1985). MST provides an intensive model of treatment based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. The purpose of this program is to keep youth in the home by delivering an intensive therapy to the family within the home. Services are provided through a team approach to youth and their families. Services include: an initial assessment to identify the focus of the MST intervention, individual therapeutic interventions with the youth and family, peer intervention, case management, crisis stabilization, and respite. Specialized therapeutic and rehabilitative interventions are available to address special areas such as substance abuse, sexual abuse, sex offending, and domestic violence. Services are available in-home, at school and in other community settings. MST involves families and other systems such as the school, probation officers, extended families and community connections. This service is a team approach designed to address the identified needs of children and adolescents with significant behavioral problems and who are transitioning from out of home placements or are at risk of out of home placement and need intensive interventions to remain stable in the community. This population has access to a variety of interventions twenty-four (24) hours a day by staff that will maintain contact and intervene as one organizational unit. This team approach is structured face–to–face therapeutic interventions to provide support and guidance in all areas of functional domains including adaptive, communication, psychosocial, problem solving, and behavior management. The service promotes the family's capacity to monitor and manage the youth's behavior. This service includes interventions that address the functional problems associated with the most complex and/or pervasive conditions of the identified population. These interventions are strength-based and focused on promoting symptom youth and family stability, increasing the youth's and family's ability to cope and relate to others, and enhancing the highest level of functioning in the community.

Appropriate for:

- Youth who have a caregiver that is willing to assume long term parenting role and caregiver who is willing to participate with service providers for the duration of the treatment; **and**
- Who display willing misconduct behaviors (e.g. theft, property destruction, assault, truancy; as well as substance use/abuse or juvenile sex offense, when in conjunction with other delinquent behaviors); **and**
- Are at imminent risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent within 30 days of referral.

Cognitive Behavioral Therapy

Description:

Psychosocial treatment for ADHD can be conceptualized into two general categories: those treatments aimed at helping the child to control his or her own behavior through cognitive techniques and those that structure the environment to manage contingencies, primarily behavioral techniques. To date, only behavioral interventions have been demonstrated empirically to be effective in controlling ADHD symptoms. These interventions include training parents to implement contingency-management programs in the home; training teachers to manage contingencies in the classroom and communicate with parents, and professionally conducted contingency management programs in either setting. While each of these approaches has been demonstrated repeatedly to be effective none of the psychosocial treatments is as effective as medication alone in control of ADHD symptoms. Also, none of these techniques has yet been consistently demonstrated to add benefit to medication treatment. As some children do

not respond adequately to medication or may have intolerable side effects, or the family may be unwilling or unable to use medication to treat ADHD, cognitive-behavioral techniques have an important role in the treatment of ADHD.

Basically, all cognitive-behavioral behavioral programs involve assessing problematic responses and determining the environmental conditions that elicit and maintain them. Strategies are then developed to produce change in the environment and therefore in the individual's behavior. Parent training typically uses different methods (reading material, group meetings, clinical assistance) to teach parents to use behavioral techniques in the home. Usually parents are taught to give clear instructions, to positively reinforce desired behavior, ignore some behaviors, and use punishment effectively. The most effective of these programs use a combination of written materials, verbal instruction in social learning principles and contingency management, modeling by the clinician, and behavioral rehearsal of specific skills (Horn et al., 1990). Families characterized by low socioeconomic status, parental psychopathology, marital conflict and lack of social support network require the most intensive interventions. Most families will benefit from education about ADHD and treatment. Information about medication, including side effects and importance of maintaining dosing schedules must be included.

Cognitive-behavioral therapy approaches describe a treatment protocol which lasts 1.5-4 years and includes the following stages: Construction of a working relationship, Symptom management, Correction of thinking errors, Emotional processing and cognitive re-evaluation of the childhood trauma, Termination. Dichotomous thinking (black and white) is the most frequent thinking error. According to Piaget, such thinking is common in children and is distinguished from more nuanced adult thinking. The consumer should be taught to correct dichotomous thinking with structured cognitive approaches. Other thinking errors commonly made include personalization and catastrophizing. They often use egocentric thinking where a standard may apply to others but not them.

Cognitive-behavioral therapy approaches have also been shown to be effective in treating children and adolescents with depressive symptoms (Kahn et al, 1990; Vostanis et al, 1996a, 1996b, 1998; Weisz et al, 1997), anxiety symptoms (Flannery , Schroeder & Kendall, 2000; Kendall, 1994) and post traumatic stress disorder (Deblinger & Lippman, 1996; Deblinger, Steer, & Lippmann, 1999). A study has also shown that an integrated cognitive-behavioral therapy approach is promising in treating adolescents with co-occurring post traumatic stress disorder and substance use disorders (Kaminer, Burleson, Blitz, Sussman & Rounsaville, 1998). An integrated approach is an approach in which one or more clinicians provides treatment for both disorders at the same time.

Appropriate for:

- Youth who are ~~is~~ between the ages of 8 and 18; **and**
- Display~~s~~ ADHD symptoms; **and**
- Are at risk of out-of-home placement, school suspension due to ADHD or are ~~is~~ currently in out-of-home placement and reunification is imminent within 30 days of referral; **and**
- Have a caregiver that is willing to assume long term parenting role and caregiver who is willing to participate with service providers for the duration of the treatment; **or**
- Display depressive symptoms; **or**
- Display anxiety symptoms; **or**
- With post traumatic stress disorder; **or**
- With co-occurring post traumatic stress disorder and substance use disorder.

Amount and Duration

- Up to 1.5 years with evidence of progress on outcomes at home and in school.

Dialectical Behavioral Therapy (DBT)

Description:

DBT is a manualized product for treatment practice that combines strategies from behavioral, cognitive, and supportive psychotherapies. It must be administered according to the treatment manual and includes concomitant weekly individual and group therapy that is conducted for one year. The individual therapist applies directive, problem-oriented techniques including behavioral skill training, contingency management, cognitive modification, and exposure to emotional cues. These techniques are balanced with supportive help such as reflection, empathy, and acceptance. Behavioral deficits and other factors that interfere with adaptive solutions are explored and remediation prescribed. Both during and between therapy sessions the therapist is actively teaching and reinforcing adaptive behaviors. The therapist withholds any reinforcement for behaviors that need to change. The emphasis is on teaching people how to manage trauma, rather than rescuing them. Treatment should be geared toward restructuring the consumer's interactions and relationship patterns with key family members as one way of reducing self-destructive behaviors. Theoretically, changes in relationships external to the family would follow. One suggestion is to develop a narrative that explains but does not condone the family's behavior. The therapist and consumer discuss the possible nature, effects and causes of the behavior and develop a strategy by which the consumer can overcome the family's resistance. The consumer is then taught to utilize specific techniques to alter patterns. Sessions are one hour weekly. Telephone contact with the therapist between procedures is part of the DBT process. Group therapy sessions are held concomitantly for two and one-half hours and follow a psycho educational format. Groups focus on three main areas: interpersonal skills, distress tolerance and acceptance of reality, and emotional regulation. Group therapists do not accept calls and direct the individual back to the individual DBT therapist.

Marsha Linehan (1991; 1993a; 1993b; 1995) pioneered this treatment as a psychosocial approach to treat adults with Borderline Personality Disorder (BPD); however, this model has been adapted for use with older adolescents (Miller et al., 1997, 2002; Rathus & Miller, 2000, 2002).

Appropriate for:

- Youth who are between the ages of 14 and 18; **and**
- Display impulsivity, self-harming behavior, threatening, emotional lability; **and**
- Are at imminent risk of out-of-home placement, school expulsion, inpatient care, or is currently in out-of-home placement and reunification is imminent within 30 days of referral.

Amount and Duration

- Up to two years with evidence of progress toward outcomes.

COLLABORATION WITH OTHER AGENCIES

Not all service needs for children with SED can be met by the mental health system alone. To facilitate collaboration around serving children with SED who are served by multiple agencies, the North Carolina Department of Health and Human Services has established state-level memoranda of agreement with relevant child-serving agencies. There are also local memoranda of agreement between local level mental health agencies and juvenile justice, social services and schools. The purpose of these agreements is to delineate responsibilities of local child-serving agencies.

It is envisioned that AP/LMEs will continue to work in collaboration with other child-serving agencies and will provide specific programs or services to support the envisioned array of services. Examples of local level collaborative programming can include problem solving courts developed in collaboration with the juvenile justice system, school-based health centers and early intervention programs supported through the collaborative efforts of mental health, public health, and educational services as described below.

Problem Solving Courts

Description:

"Therapeutic jurisprudence" or "problem-solving" courts include integration of treatment services with judicial case processing, ongoing judicial intervention, close monitoring of and immediate response to behavior, multi disciplinary involvement, and collaboration with community-based and government organizations. These principles and methods are now being employed in North Carolina's Family Courts (One Judge/One Family), Family and Juvenile DrugTreatment Courts and Court Improvement Project courts (for abuse/neglect/dependency cases).

Problem solving courts focus on the underlying chronic behaviors of individuals involved in the court system. Acting on the recommendations of a team of experts from the community, a problem-solving court judge orders the defendant to comply with an individualized treatment plan. The judge, with the assistance of a court case manager and the community-based team, exercises intensive supervision to ensure the court-involved individual - and all other parties named in the treatment plan - comply with the terms of the plan. Individualized plans may include attaining assessments, participating in a treatment program and submitting to periodic substance abuse screenings.

School Based Health Centers

Description:

There are opportunities for collaboration between AP/LMEs, schools, health providers and other community partners in developing linkages among health and mental health services provided in schools. For example, there are approximately 40 school based health centers in North Carolina. Most of these provide comprehensive health care, including mental health services.

Early Intervention Services for Children Ages Birth to Five

Description:

As a result of Special Provisions passed by the North Carolina General Assembly in 2001, the Division of Public Health developed a plan for the redesign of early intervention services for children under three years of age with or at risk for developmental delays, disabilities, or atypical development and their families. The resulting plan called for a redesign in service delivery for children under three years of age in which the existing developmental evaluation centers would become the primary managers of services for this population. While the developmental evaluation centers will manage services for children birth to three, there are identified gaps and opportunities for collaboration between mental health, public health and the DHHS Office of Educational Services for children ages three through five. Areas for future collaboration include policy development on services for children ages three through five, training in infant and toddler mental health issues for APs/LMEs and providers and transition planning for children when they become three years old.

CROSSWALK TO CURRENT SERVICE ARRAY

It is recognized that funding mechanisms and service definitions for a number of services in the envisioned service array are not yet available in North Carolina. The change envisioned by the Plan will be evolutionary. The Division will proceed at a deliberate pace to allow adequate time for the development of new services before eliminating or reducing existing services. The following grid provides a crosswalk of services currently supported through state funding to the proposed service array. The envisioned service array places an emphasis on community-based services provided in the least restrictive setting. This array also promotes flexible services that can be provided in a variety of settings such as the home, school or workplace. Support for families is an integral component of the envisioned array of services.

Current Service Array	Envisioned Service Array *
Assertive Community Treatment Team (ACTT)	
Assertive Outreach	Assertive Outreach
Case Consultation	Family Support
Case Management	Case Management
Case Support	
Community Based Services (CBS)	Community Support (elements also included in Wraparound, Intensive In-home Services and other services)
Consultation, Education and Primary Prevention	Family Support
Day/Evening Activity	
Day Treatment	
Evaluation	Evaluation
Inpatient Hospitalization	Inpatient Hospitalization
Outpatient Treatment	Outpatient Treatment
Partial Hospitalization	
Professional Treatment in Facility-Based Crisis Program	Professional Treatment in Facility-Based Crisis Program
Psychiatric Residential Treatment Facility (PRTF)	Psychiatric Residential Treatment Facility (PRTF)
Residential Treatment Level II	Residential Treatment – nonsecure
Family/Program Type	Family/Program Type (see also Services in Foster Homes and Group Settings)
Residential Treatment Level III	
Residential Treatment Level IV	
Respite	Respite
Screening	Screening
Supported Employment	Supported Employment
	New Services**
	Community Support Individual and Group-Child
	Crisis Management
	Diagnostic Assessment
	Family Support
	Independent Living Services
	Intensive In-home Services
	Multisystemic Therapy
	Specialized Diagnostic Evaluation Unit
	Transitional Services for Skill Building
	Wraparound Services

* The final list of service definitions in the envisioned service array must be approved by the Division of Medical Assistance and the Commission for MH/DD/SAS. New service definitions are anticipated to be implemented by July 1, 2004.
**Service definitions are currently in development.

Training Needs by Service Array

There are areas of the state where the provider supply is limited. The provider system as a whole needs additional training, especially in assessment and diagnoses, and implementation of best practice protocols. Current levels of education and supervision are not adequate to effectively implement the child mental health system envisioned in this Plan. Following is a delineation of the areas in which training will be needed for stakeholders and providers to put the new service array in place.

I - Assessment and Diagnosis
- Training in Evidence-Based Practice and adopted protocols
- Clinical supervision and consistent retraining
- Awareness training for those using assessments
- System for remediation
- Continuing education for providers
- Cultural competency training
- Training other agencies regarding assessments provided
- Training of advocates and parents on what to expect

II - Community Inpatient and Alternatives
- Specific training on diagnostic protocols in crisis stabilization
- Involvement of family members in training
- Training on giving testimony in court

III - Community Living
- Peer to peer mentoring
- Training to recognize risk factors, early symptoms, prevention and early intervention
- Training in Infant Mental Health
- Parent training on competencies
- Training on outcomes and functional goals
- Training regarding crisis plans
- Financial training for wraparound teams
- Training regarding how to form and work with a Child and Family Team
- Training on Child and Family Treatment Planning
- Strength-based training
- Training for other agencies (Wraparound, Person-centered Plans, and Assets)
- Best practice cognitive therapies
- Training must be acceptable for various licensures (CME, CEU, etc.)
- Cultural proficiency training

IV - School-based and Vocational
- Training for school personnel, 1 on 1 specific to kids needs
- School consultations teams/capacity
- Training on rights and self-advocacy in the educational system
- Public education to create a demand for good service
- Training for school personnel around children with high needs in school settings and children served by multiple agencies
- Train families to work with schools
- Train the trainer for community residents
- Build internal competencies within the system
- Training on how to build training and other resources in the community

Service Priorities for Building Community Capacity

Research indicates that supports to decrease reliance on restrictive care include family support, provider support for the change effort, gate keeping, moving resources to the community level, and a defined community service array. The State Collaborative recognized a need to put in place key services as defined in the service array so that children exiting state hospitals and residential facilities would have the best chance for community integration and to avoid recidivism to those facilities.

The Collaborative was first and foremost very concerned that children have not been getting adequate assessments and diagnoses based on approved criteria to determine the appropriate level of care and the best application of the service array. They further felt that most children currently in state hospitals and intensive residential settings are children for whom other local systems have failed in their individual efforts. Therefore, many of these children would be eligible for wraparound services that incorporate multiple agencies in providing services through the PCP. These plans should be in place prior to discharge from a more restrictive setting and include crisis contingency plans.

Community inpatient alternatives such as crisis residential were also considered important by the State Collaborative; however, there was a perception that better diagnosis and assessment, better child and family-centered planning, better services in the home and better collaboration could reduce the need for such services. In this prioritization, family support incorporates respite care and consultation as defined in the service array. Also, there is the need is to train case managers to promote and encourage family oriented planning, linking, monitoring and crisis response based on a PCP.

Prioritization of Outcomes

There are a number of models that can be used to measure outcomes. A key is to examine what children and families look like when they do not need the mental health system. The following provides a framework for conceptualizing child and family outcomes and child mental health system outcomes.

- Access
  - Assessment and Diagnosis
  - Timeliness
  - Crisis response
- Appropriateness
  - Right place, time and amount of service
- Attractiveness
  - Family satisfaction
  - Cultural proficiency
- Effectiveness
  - Child functional outcomes related to home, school, contact with DJJDP and DSS.
  - Developmental assets
- Cost
  - Less use of restrictive residential settings

The key measures to be monitored within this framework include the following:

1. The required service array is available in AP/LME provider networks.
2. Written protocols for best practice are adopted, staff trained and supervised in implementation of AP/LME provider networks.
3. The Division establishes clear guidelines, protocols and timeliness standards for the PCP, including the requirement for all relevant agencies to participate in the development of the Plan.

4. Flexible funds are available for PCPs.
5. State hospital and residential dollars are diverted to local care as children are returned to community settings.
6. The child and family are asked what their desired outcomes of service.
7. Children have a full assessment within 7 days.
8. The Division promulgates rules or policy to govern the elements of local MOAs including no reject/no eject, families as partners, parental support mechanisms, and who pays for the service.
9. Existing funding is maintained or increased through the period of downsizing.
10. AP/LMEs, providers, judges, agencies such as DPI, DSS, PH, DJJDP, the general public, county commissioners and the legislature are trained in the Child Mental Health Plan at least three times.
11. The Division monitors AP/LME compliance with parameters in the Child Mental Health Plan.
12. Compliance with protocols is monitored and documented by the AP/LME.
13. Families receive information on the child's condition and qualified providers to allow them to make informed choices in treatment.
14. A standardized layperson screening tool is utilized for screening that may occur at various community sites to facilitate access to mental health services without the family repeating information.
15. The number of children who are in custody to receive mental health services is reduced.
16. Children who commit non-violent crimes are diverted from detention.
17. Customers are satisfied with the AP/LME care coordination/community supports referral capacity.
18. The AP/LME does needs assessment annually that involves consumers to determine the adequacy of the provider network.
19. Persons with emergent needs are seen face-to-face within one hour.

Family and state and local collaborative involvement in monitoring is critical to the credibility of this Plan for children. A major part of the North Carolina Reform effort is to support self-direction and advocacy, meaningful family and stakeholder involvement and quality improvement. The Division will use a Plan, Do, Check and Act Model wherein once the Child Mental Health Plan is completed and implemented, data will be made widely available to the public on outcomes related to the Plan. Families and other stakeholders are integrated in statewide quality improvement committees as well as committees at the local AP/LME level. Efforts will be increased to make participation meaningful through surveys, focus groups, policy-making committees, licensing and site review teams that include families, and key state and local agencies. Families and stakeholders will be taught how to participate in the evaluation process through available training and education. Recommendations will be incorporated in improvement efforts and improvements are then monitored for success.

The Communication Approach

In order to ensure that implementation this Plan is successful, a communication plan which utilizes multiple mechanisms of communication and targets multiple stakeholders is required. A three-tiered approach to communication will be used:

- Level 1
  - A general overview of the Child Mental Health Plan and its components provided by Department heads to their staff and constituents.
- Level 2

- Information regarding the Plan tailored specifically for professionals to present to other professionals in their field.

- Level 3
  - Families providing testimonials and grass roots stories of the importance and success of such reform.

Operationalizing the Child Mental Health Plan

This section provides an overview of the steps the Division of MH/DD/SAS will take during fiscal years 04 and 05 to operationalize the Child Mental Health Plan. During this period the Division will take a series of discrete steps that will lead to the following outcomes:

- **SFY 03/04 Outcomes:** (1) Completion of the 7 critical success factors in the Plan based on related principles and corresponding expectations, and (2) development of the essential structures to support the Plan including structures for downsizing state facilities and residential placements.

- **SFY 04/05 Intended Outcome:** (1) Transitioning the service delivery from restrictive settings to community based settings through the expansion of the array of community services and supports.

Clear direction and policy is needed before the concepts and principles that are embedded in the Plan can be put into operation at the state and local level. Some of the major areas include: expansion of community capacity associated with the Olmstead decision and state facility downsizing; facilitating increased collaboration among state and local agencies; reorienting the service delivery system to the value of family preservation/in home care; and providing training and education regarding the intent of the Plan.

The major areas of the Plan to be operationalized include the following:

- Community Capacity Expansion
- Reducing Reliance on State Institutions and other restrictive modes of care
- Collaboration among Child- Serving Agencies and Families
- Financing and Funding Mechanisms
- Quality Improvement Processes
- Training

A summary of the major tasks to be achieved, by SFY 03/04 quarters, are as follows:

SFY 03/04 1st Quarter (July 1, 2003 through September 30, 2003)

- Finalize and distribute the Child Mental Health Plan.

- Develop and implement a public awareness campaign concerning the Plan.

- Develop guidelines regarding community collaboratives, and child and family teams which includes mechanisms to address:
  - Capacity,
  - Access,
  - Barriers, and
  - Funding

- Begin to reduce reliance on restrictive levels of care, in accordance with the State Plan and Child Mental Health Plan, by assessing the needs and developing discharge plans for the current seven residents of the Eastern Adolescent Treatment Program (EATP).

- Provide start up and ongoing funding to AP/LMEs to expand community capacity to serve those children who are currently being served or would be served by the EATP.

SFY 03/04 2nd Quarter (October 1, 2003 through December 31, 2004)

- Establish criteria for determining community capacity needs that reflect the age-specific, developmental needs/ levels of care for children ages birth through 18.

- Discharge the seven current residents of the EATP to appropriate services and close the unit.

- Finalize service definitions and refine community services array.

- Develop performance measures to assess critical success factors, including objective measures and measures of child/family perceptions and satisfaction.

- Develop child/family outcome measures, including functional, behavioral and environmental measures and child/family satisfaction measures.

- Develop rules or policy to govern ~~the~~ elements of local collaborative agreements which may include
  - No reject/no eject;
  - Families as partners, parental support mechanisms; and
  - Responsibility for payment of the service.

- Provide training on the Child Mental Health Plan to: AP/LMEs, Providers, Judges, local agencies, etc.

SFY 03/04 3rd Quarter (January 1, 2004 through March 31, 2004)

- Begin collecting data on child and family outcomes for children discharged from the EATP.
- Develop and disseminate guidelines regarding system of care philosophy, principles and practices, including community collaboratives and child and family teams.

- Develop strategy to fund and support community collaboratives and family involvement.

- Assess the current use and policies governing the use of all public financial resources available for child mental health services to ensure consistency with Plan's overall direction.

- Train AP/LME and division staff regarding QI activities around the Child Mental Health Plan.

- Train Child and Family Teams regarding use of individual data for PCP goal setting and evaluation.

- Provide "bridge funding" to AP/LMEs to expand community capacity to serve children who are currently served or would be served in state operated child mental health residential facilities/units and state hospital PRTFs.

- Conduct evaluation of children currently served by state operated child mental health residential facilities/units and state hospital PRTFs.

SFY 03/04 4th Quarter (April 1, 2004 through June 31, 2004)

- AP/LMEs develop and submit plans for expanding array of community based supports and services. Plans are to include:
  - Analysis of needs/gaps.
  - Evidence of collaboration and coordination with child-serving agencies and families.
  - Evidence of consideration of family, community and cultural values in developing service array.
  - Evidence of a process of accessing informal, community and natural supports.

- Promote training and technical assistance in evidence-based practice and outcomes-based accountability for agencies, families, and providers.

- Begin collecting data on performance measures.

- Seek legislative approval to lift restrictions for CTSP funding such that funds can be used for all children receiving mental health services.

- Incorporate requirements for service array in LME Performance Agreements.

- Establish consistent Levels of Care criteria for state facility placement and out-of-home placement with prior authorization.

SFY 04/05 1st Quarter (July 1, 2004 through September 30, 2004)

- Provide ongoing funding to AP/LMEs to support community capacity expansion.

- Develop discharge plans for all children in state operated child mental health residential facilities/units and state hospital PRTFs utilizing Child and Family Teams and Person-Centered Planning principles.

SFY 04/05 2nd Quarter (October 1, 2004 through December 31, 2004)

- Establish analysis and reporting plan, including benchmarks and targets.

- Develop a training, consultation/TA plan using evidence based practices for children and youth.

- Begin collecting data on child and family outcomes for children discharged from at state operated child mental health residential facilities/units and state hospital PRTFs (pre- and post-discharge and periodically thereafter).

- Conduct evaluations for all children served in Umstead's latency age program.

- Based on review of data related to community capacity expansion and child and family outcomes, close Whitaker School and PRTFs at Umstead and Dix Hospital.

- Provide "bridge funding" to AP/LMEs who are to transition children from the Umstead Hospital program for latency age children to their home community.

SFY 04/05 3rd Quarter (January 1, 2005 through March 31, 2005)

- Provide on-going technical assistance to AP/LMEs and local stakeholders regarding implementation of system of care philosophy, principles, and practices including community collaboratives and child and family teams.

- Develop discharge plans for children served by the Umstead Hospital program for latency age children.

SFY 04/05 4th Quarter (April 1, 2005 through June 31, 2005)

- Establish a plan for prevention, early identification and intervention for children birth through age 18 and transitions into adulthood.

- Develop ways to maximize coordination of funding and resources between agencies at the local level.
- Begin analyzing progress of implementation toward Plan goals, using performance data and aggregate child/family outcomes data and Plan improvements.
- Based on review of data related to community capacity expansion and child and family outcomes, close latency age program at Umstead Hospital.

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Appendix A
Issues to be Monitored

RESOURCES:

- Maintain existing funding while shifting funding from restrictive care to the community and create a flexible pool of funds to be utilized locally for PCPs. **
- Informal, community and natural supports are accessed before using or simultaneously with the use of public services.
- Communities develop directories and means for accessing community and natural supports. **
- Communities coordinate existing resources/services including Early Childhood services.

- COMMUNICATION:
- Marketing, education and training of families in rights and responsibilities must be done at the local level.
- Early intervention and prevention activity should be funded and promoted.
- Public health education includes mental health and parenting education.
- The legislature, general public, local officials and key agency staff must be trained to understand the Plan.**

- PARTNERSHIP WITH STAKEHOLDERS:
- Involve the Collaborative in CQI efforts with at least 50% being families.
- Provide training and supports for families to participate in a meaningful way.
- Create other mechanisms for families and other stakeholders to be involved in monitoring outcomes.
- Train other stakeholders in the Plan.
- Encourage community capacity building such as neighborhood resource centers, parent skills training carried out in variety of locations (particularly schools), expand community safety nets, address transportation issues, and provide conflict resolution training.
- Work with physicians to provide training and consultation on child psychiatric/medication issues.
- Work with communities to help each child have a medical home.
- Child and family are asked what the desired outcomes of service are.**
- State monitors AP/LME compliance with PCPs.**
- Needs assessment and adequacy of provider network.**

BEST PRACTICES:

- Define a minimum required statewide set of services with written standards. **
- Implement and monitor a policy for least restrictive care.
- Adopt best practices that include cultural competencies. **
- Conceptualize children holistically.
- Consider family, community and cultural values in establishing the service array.
- Provide training to the AP/LME, providers and families.
- Recruit competent and qualified providers.
- Create policy and criteria for development of the Person-centered Plan (PCP).**
- Children have a full assessment within 7 days.**
- AP/LMEs monitor provider compliance with best practice protocols.**
- Families receive information on the child's condition and qualified providers to allow informed choice.**

ACCESS:

- Establish convenient locations and monitor timeliness standards. **
- Create one screening application to be used by all agencies.**
- Make the array of services available statewide.
- Establish gate keeping for entry to restrictive care.

- Recognize that there is a set of required minimum services for consistency statewide.**
- Ensure that there is specialist availability to assess target populations with high needs.
- Provide outreach to schools, courts and children in foster care.**

ACCOUNTABILITY:
- Establish outcome measures and benchmarks.
- Functional outcomes are designed with input from stakeholders.
- Establish process for collecting evaluation data.
- Clarify CQI expectations in contracts and MOAs.

MEMORANDA OF AGREEMENT:
- State divisions and departments set policy for collaboration and boundaries.
- All state contracts and MOAs include the requirement for collaboratives.
- Local collaboratives develop agreements.
- Statewide training is provided in development of agreements at the local level.
- All agreements must minimally include continuity of service agreements, no eject/no reject agreements, families as partners, parental support mechanisms, and who pays for the service.**

**Outcomes the Division will monitor on a regular basis.

Appendix B
Planning Participants

The Division extends its appreciation to the following planning participants who devoted much time and effort to the development of this Plan.

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